

Domestic Homicide Review
Rosemary/2017
Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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1. Introduction

- 1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Rosemary Taylor, a resident of Town A, prior to her death on 29th June 2017. On that day, an ambulance crew and police officers went to a car park in Town B, following a call from members of the public. They found Rosemary suffering from stab wounds and she died at the scene.
- 1.2 Simon Vincent was also at the scene and he was arrested on suspicion of murdering Rosemary. He was subsequently charged with this crime.
- 1.3 Simon was tried and found guilty of Rosemary's murder, and on 6th February 2018 he was sentenced to life imprisonment with a recommendation that he should serve at least 26 years.
- 1.4 This DHR examines the involvement that organisations had with Rosemary (a white British woman, aged 23 years) and Simon (a white British man, aged 25 years), between 1st January 2013 and Rosemary's death.
- 1.5 The key reasons for conducting a Domestic Homicide Review (DHR) are to:
 - a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims;
 - b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;
 - c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
 - d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
 - e) contribute to a better understanding of the nature of domestic violence and abuse; and
 - f) highlight good practice.
- 1.6 This review began in July 2017, following a decision by Kent Community Safety Partnership that the case met the criteria for conducting a DHR.
- 1.7 This report has been anonymised and the personal names contained within it are pseudonyms, except for those of DHR Panel members.

2. Terms of Reference

- 2.1 The Review Panel first met on 17th August 2017 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form [Appendix A](#) of this report.

3. Methodology

- 3.1 The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Rosemary and/or Simon. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.
- 3.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Rosemary or Simon during the period covered by the review.
- 3.3 In addition to IMRs, one organisation provided a Summary Report and documentation about its involvement in a matter involving Simon.

4. Involvement of Family Members and Friends

- 4.1 The following family members were known to the Review Panel:

	In relation to:	In relation to:
Name:	Rosemary Taylor	Simon Vincent
Linda Taylor	Mother	
Peter Taylor	Father	
Graham Vincent		Father

- 4.2 The Independent Chairman met with Rosemary's parents in October 2017 to explain the purpose of the review. A copy of the Home Office DHR leaflet for family members was given to them. The content of this was explained, including the availability of independent advocacy services.
- 4.3 The Independent Chairman met Rosemary's parents again in May 2018 to further explain the DHR process and to discuss the Overview Report and its

conclusions, lesson identified and recommendations. The Independent Chairman did not have access to Rosemary's friends.

5. Contributing Organisations

5.1 Each of the following organisations were subject of an IMR:

- Kent Police
- Kent & Medway NHS and Social Care Partnership Trust
- GP Practice 1 (Rosemary's GP) *
- GP Practice 2 (Simon's GP) *

* GP Practice IMRs were completed by the Clinical Commissioning Group in whose area the practice is based. To protect the anonymity of Rosemary and her family, GP practices are not named.

5.2 In addition to the IMRs, Staffordshire Police provided a chronology and supporting documents about an incident that involved Simon.

6. Review Panel Members

6.1 The Review Panel was made up of an Independent Chairman and senior representatives of organisations that had relevant contact with Rosemary and/or Simon. It also included a senior member of the Kent Community Safety Team and an independent advisor from a Kent-based domestic abuse service.

6.2 The members of the panel were:

Simon Brownsword	Staffordshire Police (Final meeting)
Kate Bushell	NHS Clinical Commissioning Group
Jackie Hyland	Choices Domestic Abuse Service
Susie Harper	Kent Police
Catherine Collins	Kent Adult Social Services
Richard Hill	Medway Council
Paul Pearce	Independent Chairman
Shafick Peerbux	Kent Community Safety
Jen Sarsby	NHS Clinical Commissioning Group
Cecelia Wigley	Kent and Medway NHS & Social Care Partnership Trust

6.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Rosemary or Simon. The panel met on three occasions during the DHR.

7. Independent Chairman and Author

- 7.1 The Independent Chairman, who is also the Author of this Overview Report, is a retired Senior Police Officer who has no association with any of the organisations represented on the panel and who did not work in Kent or Medway. He has enhanced knowledge of domestic abuse issues and legislation, and an understanding of the roles and responsibilities of those involved in the multi-organisation approach to dealing with domestic abuse.
- 7.2 The Independent Chairman has a background in conducting reviews (including Serious Case and Safeguarding Adult Reviews), investigations, inquiries and inspections. He has carried out senior level disciplinary investigations and presented at tribunal. He has completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

8. Other Reviews/Investigations

- 8.1 Kent Police voluntarily referred the case of Rosemary's death to the Independent Office for Police Conduct (IOPC), formerly the Independent Police Complaints Commission. The IOPC decided that the case was suitable for Kent Police to investigate locally. The result of this investigation is outstanding.

9. Publication

- 9.1 This Overview Report will be publicly available on the Kent County Council website and the Medway Council website.

10. Background Information

10.1 Rosemary Taylor

- 10.1.1 Rosemary was born in 1994 and lived with her parents in Kent throughout her life. At the time of her death she was studying health, sports and nutrition at a university in the county. She was in the final year of her studies and was on course to achieve a first-class honours degree. In the days before her death she had enrolled on a personal training course to complement her studies.
- 10.1.2 Rosemary was a bright, popular young woman with many friends. She battled with bulimia and the anxiety it brought on, which for some years had defined her life. By the time she started a relationship with Simon,

she had recovered from this and had a positive outlook on life. She had a bright future ahead of her when Simon killed her.

10.2 Simon Vincent

- 10.2.1 Simon was 25 years old at the time of Rosemary's death. He lived with his father and step-mother in Town C. He had a brother who lived abroad. At the time of Rosemary's death, he worked for a double-glazing company in sales.
- 10.2.2 From 2013, Simon suffered from mental health problems, for which he was referred to secondary mental health services. He felt that he might have been suffering from bi-polar disorder (and told Rosemary he was) but this was not formally diagnosed. In February 2017, five months before Rosemary's death he was discharged from mental health treatment.
- 10.2.3 Simon had a history of using text messages to harass women who no longer wanted to see him. In 2013 he had harassed a woman (Sally Ross) he had been out with on one occasion in Staffordshire, where he was living at the time. She reported him to the police in May that year and a police officer sent him a text and a voicemail message telling him to stop. No further reports were made to the police; Sally confirmed in the witness statement taken from her by a Kent Police officer investigating Rosemary's death, that contact stopped after her holiday in July 2013.
- 10.2.4 In May 2016 in Kent, he harassed a woman, Stacey, with whom he had a brief relationship. He stopped when she told him if he came to her flat again, she would report him to the police. Stacey did not hear from Simon again and did not report the harassment to the police or other agency.

10.3 Relationship Between Rosemary and Simon

- 10.3.1 Rosemary and Simon made contact with each other through the social media application Tinder in July 2016, but they did not meet until November that year. Soon after their relationship began, Rosemary took Simon to meet her parents and apart from some apprehension when she told them he had bi-polar disorder, they had no concerns about him then.
- 10.3.2 In April 2017, while staying in a hotel, Rosemary and Simon had a disagreement. Her parents were also staying at the hotel and her mother witnessed part of the disagreement. Rosemary told her that Simon had been recording and videoing her.

- 10.3.3 Rosemary and Simon went on holiday to Tenerife together in May 2017 and shortly afterwards, on 17th June, she told him that their relationship was over. Following this, he posted messages on Facebook about their break up and made false allegations about her taking drugs. She blocked him on Facebook, after which he posted derogatory messages about her to her family and friends.
- 10.3.4 On 22nd June 2017, Rosemary and her mother went to their local police station and reported the social media harassment by Simon. He was spoken to by a police officer and agreed to remove the social media posts. On 25th June, Rosemary again contacted Kent Police to say that Simon had put further posts on social media, in which he stated he had been cleared by police and no further action was being taken. When contacted by the police officer two days later, he agreed to remove these. The officer also asked Rosemary to remove some posts she had made.
- 10.3.5 On the evening of 28th June 2017, Rosemary saw Simon in a public house; he was with another girl. The following day, Rosemary was at a gym when Simon came in and spoke to her. She sent a text to her mother and a WhatsApp message to a friend, telling them that he had been there. When she left the gym and got into her car in the car park, Simon came up to it, opened the door and attacked her. He stabbed Rosemary, causing her death, and he waited for police to arrive.
- 10.3.6 Careful consideration has been given to whether issues of equality or diversity were contributing factors to this tragic event. Simon suffered from mental health issues and his treatment is examined in section 11 below. There is no evidence that organisations treated Rosemary in a way that indicates a lack of consideration of equality and diversity issues. Although she was young, when she reported her fears and concerns, about Simon's messages and social media posts, she was taken seriously.

10.4 Equality and Diversity

- 10.4.1 Careful consideration has been given to whether issues of equality or diversity were contributing factors to this tragic event.
- 10.4.2 Rosemary had suffered from bulimia. The only organisation she was involved with during the review period that would have known this was her GP practice. She had received treatment for the condition, which she was managing during her the period she knew Simon. Simon suffered from mental health issues and his treatment is examined in section 11 below.

- 10.4.3 There is no evidence that organisations failed to take into account issues of equality and diversity that would have been known to them.

11. The Facts and Analysis of Organisations' Involvement

11.1 Introduction

- 11.1.1 This section contains facts and analysis of the involvement that Rosemary and Simon had with organisations between 1st January 2013 and Rosemary's death on 29th June 2017 (referred to in this report as the review period). The facts are based on IMRs and reports submitted by those organisations and on conversations the Independent Chairman had with Rosemary's parents. The analysis is based on the facts; from it come conclusions, recommendations and lessons identified.
- 11.1.2 This section includes abbreviations, acronyms and references to terms that will be familiar to professionals working in relevant organisations, but which may need further explanation for other readers. In such cases, the reader is referred to the glossary in [Appendix B](#).

11.2 Staffordshire Police

- 11.2.1 Following media publicity about Simon being charged with Rosemary's murder, a woman named Sally Ross, who lives in Staffordshire, contacted Kent Police. A friend of hers had recognised Simon from a newspaper photograph as someone Sally had reported to Staffordshire Police some years previously for harassing her.
- 11.2.2 At 11.30am on 27th May 2013, Staffordshire Police received a call from Sally's mother. The call was recorded, and the call taker opened a log on Staffordshire Police's computerised incident management system, which is known by the proprietary name [Storm](#).
- 11.2.3 Sally's mother reported that the tyres of her car had been slashed, and someone was harassing Sally by sending her text messages. From what she said, both at the start of the call and subsequently, it was clear Sally's mother thought the harassment and damage were connected. She named the suspect for both as Simon Vincent. The call taker recorded *'There are months of abusive texts, on last night's text he was saying he was "in the back". The texts are generally of a threatening nature and name calling. We kept thinking he would get bored and go away if we ignored him.'*

- 11.2.3 Storm generated questions, prompting the call taker to ask about the vulnerability of the caller. The first question was *'Is [the] caller vulnerable from [the information they have] provided?'* The call taker recorded the answer as *'No'*.
- 11.2.4 The call taker entering 'no' to the question prompted by the Storm about whether the caller was vulnerable, demonstrates the risk of asking closed questions about a potentially complex situation. Based on what Sally's mother had said at that stage she, as the caller, was not vulnerable. Her description of Simon's behaviour potentially made Sally vulnerable, but the Storm did not cater for this.
- 11.2.5 The rest of the call was about the damage to the car, and the call taker recorded that an appointment was made for a police officer to meet Sally's mother at her home at 3pm that afternoon. This was an appropriate and proportionate response to the reports she had made, indicating the call taker understood the potential seriousness of the situation.
- 11.2.6 About 3.45pm the same afternoon, the police officer who kept the appointment recorded on the Storm log that he had spoken to Sally's mother. He took details of the damage to her car, which he recorded as an offence of criminal damage. Because the offender had not been seen, there was no potential forensic evidence and no CCTV, the officer recorded on the Storm that *'There is at this stage no evidence to say who caused the damage.'* The crime report was closed without any further investigation.
- 11.2.7 About half an hour later, the same officer recorded that he had seen and spoken to Sally about the text messages she had been receiving from *'a male she knows as Simon Vincent, aged 21'*. The officer further recorded *'Recently his texts have become more frequent and on looking at these texts I can confirm that they are not of a threatening or offensive nature, they basically go on about what she is up to.'* He added *'Sally tends to broadcast via Twitter what she is doing and therefore this Simon knows her business.'*
- 11.2.8 In terms of safeguarding advice, the officer recorded that Sally had blocked Simon on Twitter (after which he could not see her posts) and was contacting her mobile phone provider asking them to block his number. In addition, *'Sally has been strongly advised regarding publicly announcing what she is doing and where she is going as there is no guarantee that Simon is who he says he is.'*

11.2.9 The officer recorded that Sally asked for Simon to be suitably advised that she did not want him to contact her and should he continue to do, she would pursue a complaint of harassment. She signed the officer's pocket notebook to that effect.

11.2.10 Staffordshire Police's 'Policy for Harassment', implemented in March 2007, was current at the time of this incident. It stated:

"Where a complainant indicates that they wish to take a civil remedy and no longer involve the Police at this stage there is no requirement to record the incident as a crime, other than a full [pocket notebook] entry signed by the complainant and a completed [Storm] Incident Log."

11.2.11 The officer complied with the policy: Sally signed his pocket notebook and a crime of harassment was not recorded. The officer also wrote that there was insufficient evidence to serve a [Police Information Notice](#) on Simon because '*...the conversations have been encouraged by Sally and as stated are not threatening.*'

11.2.12 The 'Policy for Harassment' also stated:

"Where it is clear that the actions complained of were reasonable, a [[Police Information Notice](#)] should not be issued. A full [pocket notebook] entry should be made and the [Storm] log completed accordingly."

11.2.13 The officer also complied with the policy in this respect; he made both a pocket notebook entry and completed the Storm log. The use of the term '*reasonable*' to describe an alleged harasser's actions is a subjective judgement, about which the complainant may feel differently to the officer. It would have been clearer if the policy used the term '*lawful*' instead.

11.2.14 In cases involving domestic abuse, Staffordshire Police officers complete a Domestic Incident Assessment Log (DIAL). This case did not fit the cross-government definition of [domestic abuse](#), therefore a DIAL risk assessment was not completed. Staffordshire Police has since reviewed its response to stalking. The [Domestic Abuse, Stalking and Harassment \(DASH\)](#) Risk Assessment is carried at the point of call and during investigations to assess the risk and vulnerability for identified victims of stalking.

11.2.15 There is no record that Sally was given contact details of a domestic abuse support organisation. Although the actions of Simon did not meet the definition of [domestic abuse](#) due to the nature of their relationship, it

would have been good practice to have done this. It would have enabled her, if she had wished to, to have talked to staff who understood the effects of stalking and harassment from a victim's perspective and who may have been able to give her additional advice and support.

- 11.2.16 As part of the investigation into Rosemary's death, Kent Police interviewed Sally and took a witness statement from her. This contained more detail than the Staffordshire Police officer recorded at the time, including how Sally met Simon and how that meeting ended, prompting texts and other communication from him. Her recollection of the order of events that happened more than four years previously is not clear, but she remembers Simon sending her a message which stated *'I'm gonna fly out and drown you'*, referring to her being on holiday abroad in July 2013. He sent another which said, *'If you ever touch my family I'll stab you'*, despite Sally having never met or mentioned his family.
- 11.2.17 These text messages were explicitly threatening towards Sally. Her only recorded contact with Staffordshire Police was in May 2013, so it may have been that these messages and some of the other potentially sinister behaviour she describes in her statement, which together constituted stalking, did not happen until after then.
- 11.2.18 Having agreed a course of action with Sally, the police officer recorded calling Simon's mobile phone number, which she had given him. There was no reply and the officer said he would make further attempts. He asked for the Storm record to be closed about 5.05pm the same day, having recorded on it *'Numerous attempts made, no answer to ringing. I have left him a voicemail and also sent him a text message warning him to stop making contact with Sally. Unless further info comes from Sally with the [registration number] of his vehicle, the whereabouts of this [Simon] will remain unknown, hence why voicemail and text message have been sent.'* About 5.35pm that day, the Storm record was closed; there was no further contact between Staffordshire Police and either Sally or her mother.
- 11.2.19 A text or voicemail message is not a reliable way of giving advice or a warning to a person who has been harassing someone. There is no confirmation that the intended recipient has read or listened to it. In addition, neither allows the sender to judge the response of the intended recipient or ask them questions with any certainty of receiving an answer. To do this requires at least voice contact with them.
- 11.2.20 The officer who attended dealt with the damage to Sally's mother's car and the harassment of Sally separately. There was no direct evidence to

connect Simon to the damage caused to the car. However, the Storm record states that Sally's mother had spoken to her neighbours, one of whom had seen a tall white man, who the neighbour could not identify. The neighbours' cars had not suffered damage, further suggesting it was not a random act. More professional curiosity and further enquiries into a possible link might have been expected.

- 11.2.21 The wording of the safety advice the officer gave Sally about not '*...publicly announcing what she is doing...*' was pragmatic and could be given appropriately to anyone using social media, whether they had been subject to harassment or not. However, combined with the lack of effort to find out who Simon was or where he might be (the '*numerous attempts*' to contact him were completed before 5.05pm that afternoon), it might give the impression that the officer felt Sally had brought the harassment on herself. Recording that '*...the conversations have been encouraged no doubt by Sally*', for which there was no recorded supporting evidence, tends to support that assertion.
- 11.2.22 The potential relevance of Staffordshire Police's involvement hinges on whether, had things been done differently, Kent Police might have found out about the 2013 incident in Staffordshire when Rosemary reported her concerns about Simon (as described in sub-section 11.3 below). This could have been achieved in two ways: first, if Simon had been named as a suspect for a crime, a search of the [Police National Database \(PND\)](#) would have revealed this. Second, if he had been cautioned or convicted of a criminal offence, this would have been recorded on the [Police National Computer \(PNC\)](#). Unlike information recorded on Storm, that on the PND and PNC is available to all police forces.
- 11.2.23 The damage to Sally's mother's car was recorded as a crime, but Simon was not recorded as a suspect because the officer did not feel there was enough evidence to justify that. The harassment was not recorded as a crime. Therefore, Kent Police could not have found out about the Staffordshire Police involvement by searching the PND or PNC.
- 11.2.24 In 2016, Staffordshire Police revised its Stalking and Harassment Policy, which is now reviewed annually. The policy now includes the requirement to record stalking as a crime, even if the victim does not want the police to take further action. This means that if the victim makes a further complaint or the alleged perpetrator comes to notice again, there will be a permanent record available to those taking further reports, which can be used to inform and influence the action taken.

- 11.2.25 Staffordshire Police has implemented new procedures for the assessment of person's vulnerability. In accordance with a recommendation made by Her Majesty's inspectorate of Constabulary, Staffordshire Police no longer issue [Police Information Notices](#). New procedures have been implemented including vulnerability assessment at the point of call, a stalking risk assessment and a training programme for staff. The force has identified a lead officer for stalking and has trained 25 Single Points of Contact (SPOC) to assist and advise police officers and staff who are dealing with complaints of stalking and harassment. The SPOCs form a working group to ensure a robust and consistent approach is provided to victims of stalking and harassment.
- 11.2.26 Staffordshire Police have reviewed the way the reports of damage to Sally's mother's car and the harassment of Sally were dealt with. The conclusion is that the investigations of the offences fell below the required standard. As a result, a police officer will receive management advice.
- 11.2.27 Staffordshire Police must submit a report to the Kent and Medway Community Safety Partnership detailing how, if this case was reported today, the degree of victim focus would be greater, based on their revised stalking and harassment policy. **(Recommendation 1)**
- 11.3 Kent Police
- 11.3.1 The first relevant involvement that Rosemary had with Kent Police during the review period was on 22nd June 2017, when she and her mother went to the police station in Town D. They initially spoke to a police staff employee (PSE1) who was on duty at the front counter.
- 11.3.2 Rosemary reported that since ending her relationship with Simon on 17th June 2017, he had been harassing her using the social media applications Facebook and Instagram. PSE1 created a computer record of Rosemary's report on [Storm](#). The initial entry was:

[Rosemary] has attended front counter very upset at the posts on Instagram and Facebook by her ex-partner [Simon]. States she broke up with him on Saturday night and then they exchanged items back to each other Sunday. States she believed that it was amicable but then had to ask him to leave on Sunday as he was trying to pressure her into staying with him. Rosemary suffers with bulimia and Simon is aware of this and was telling her that she is ill and that she would only get better if she stayed with him.

- 11.3.3 Rosemary said that Simon had asked her not to block him on Facebook, which she agreed, but she blocked him on other social media applications. He then posted messages to her on Facebook about their break up and made false allegations about her taking drugs. He 'tagged' the messages to those of her family and friends who had Facebook accounts, meaning they were able to read them.
- 11.3.4 On 19th June 2017, because of these posts, Rosemary blocked Simon on Facebook. He then posted derogatory messages about her to her family and friends, so she unblocked him in order to facilitate reporting him. Rosemary said that Simon had stated there was '*...more to come*' but had not specified what he meant by this.
- 11.3.5 To assist in assessing the risk to the person making a report of harassment, Storm generates questions they should be asked. Rosemary was asked these by PSE1, who recorded her answers. Kent Police may also use the [THRIVE](#) principles to assess the appropriate response to harassment. This was not necessary in this case, because when PSE1 decided Rosemary's report needed to be dealt with by a police officer, a police constable (PC1) was available to speak to her at the time, in the police station.
- 11.3.6 PC1 spoke to Rosemary and her mother. He completed a [DASH](#) risk assessment with Rosemary. When asked if she was frightened, she said she was worried that Simon would come to her home. She was unsure what he was capable of, but he had not been violent towards her during their relationship.
- 11.3.7 PC1 then checked the [Police National Computer](#) and the Kent Police [Genesis](#) intelligence system. These checks confirmed that Simon had no recorded convictions, nor had there been any recorded police involvement with him in Kent.
- 11.3.8 A search of the [Police National Database \(PND\)](#) was not carried out. Access to the PND is more restricted than access to the PNC, meaning fewer officers and staff can search it. PC1 was not authorised to access the PND. The level and length of training required to search the PND accurately and comprehensively is significant. Its strategic aims are to assist in combatting serious crime, and although information about lower levels of crime are recorded on it, searches are not conducted routinely for less serious crime. As described in Section 11.2, Simon was not recorded as a suspect for any criminal offence, so a PND search would not have found any record of the Staffordshire incident.

- 11.3.9 PC1 spoke to Simon on the telephone in the hearing of Rosemary and her mother, but without his knowledge. He was asked to remove all social media posts relating to her and not to contact her or her friends. Rosemary's mother recalls that he consistently asked why he was being asked to do this, but he eventually agreed to remove the posts.
- 11.3.10 PC1 then gave Rosemary safeguarding advice about what to do if she encountered Simon. This included remaining in a public place should she see him, ensuring doors and windows of her home were secure, and calling 999 if she felt threatened.
- 11.3.11 PC1 felt that although upsetting for Rosemary, Simon's actions did not constitute a course of harassment. Rosemary was concerned that Simon might post a photograph of her on social media, which would cause her embarrassment. Her concern was understandable, but Simon did not post the photograph. Subsequent examination of his mobile phone following his arrest did not reveal pictures of the nature that had concerned Rosemary.
- 11.3.12 Taking all that he heard from both parties into account and having consulted his sergeant, PC1 graded the DASH risk assessment as Standard. He recorded Rosemary's report as a domestic abuse [secondary incident](#). As well as being based on a victim's answers to set questions, the DASH grading is influenced by the professional judgement of the professional completing it. PC1 considered the messages and Facebook posts, and decided that that they did not constitute a criminal offence. He established there had been no previously reported incidents between Rosemary and Simon and that Simon had no previous convictions. There was no indication of an immediate danger, Rosemary and Simon lived in different towns and he did not have access to her home address (he did not have a key).
- 11.3.13 PC1 then completed an electronic [secondary incident report](#), which he forwarded to the Incident Management Unit (IMU). One of the functions of the IMU is to consider whether an incident has been correctly recorded in accordance with the Home Office criteria for crime recording.
- 11.3.14 After Rosemary and her mother left the police station, Simon phoned Kent Police three times that day asking to speak to PC1. When they spoke, Simon said that since their last conversation, in Rosemary's hearing, a friend had told him that she had posted on social media that he was in trouble with the police.

- 11.3.15 About 9.30am the following morning, 23rd June, Simon went to the police station in Town E. He repeated what he had heard from a mutual friend: that Rosemary had posted on Facebook and Instagram that nobody should speak to him because he was in serious trouble with the police. Simon said that a lot of mutual friends had deleted him from their social media accounts because of Rosemary's posts. He added that '*rumours were rife*' and because he had a good job which relied on his reputation, he was concerned about the effect the posts might have on his life. PC1 advised him to delete Rosemary from his social media accounts. He also told Simon that Rosemary had been advised to delete him from her accounts. Simon said that she had not done so, and that she had tried to contact him. The officer also asked Rosemary to remove the posts she had made.
- 11.3.16 The same morning, a review of the case was undertaken in the Vulnerability Hub within the IMU. The hub is staffed by police officers and police staff, a key part of whose role is to ensure that the vulnerable victims are receiving the correct police response. No actions were raised, indicating that the reviewer found that the matter was being managed correctly up to that point. However, a decision was taken to record Rosemary's report as a crime of Harassment Without Violence contrary to [S.2 of the Protection from Harassment Act 1997](#).
- 11.3.17 Although PC1 had decided that Rosemary's report did not constitute a crime and had submitted a secondary incident report, the decision in the Vulnerability Hub was that it should be recorded as a crime. The accuracy of crime recording by police forces is regularly scrutinised by Her Majesty's Inspectorate of Constabulary, which in 2014 published a document entitled [Making the Victim Count](#). The focus was on police under-recording crime, which can result in cases not being investigated, victims receiving a poor service and offenders not being sanctioned. In November 2015, Her Majesty's Chief Inspector of Constabulary [wrote to Chief Constables and Police & Crime Commissioners](#) informing them that there would be a rolling programme of inspections of all police forces, examining the accuracy of crime recording.
- 11.3.18 This review does not seek to judge whether the circumstances of Rosemary's report should have been recorded as a crime. The Home Office Counting Rules, which set out when and how crimes are recorded, are complex; the document for [violent crime](#) alone (which includes stalking and harassment) is 88 pages long. Although the rules are quite prescriptive, there remains an element of professional judgement,

because in some circumstances, the decision whether a crime has been committed or not is finely balanced.

- 11.3.19 Either a secondary incident or a crime report relating to domestic abuse would have resulted in a referral to Victim Support if Rosemary had agreed to this. The box on both was ticked 'No' indicating that she had declined a referral.
- 11.3.20 Having reviewed the crime on the morning of 23rd June, a further review was undertaken in the Vulnerability Hub in the afternoon. This was because the enquiry record remained open following the contact from Simon that morning. The reviewer recommended that Simon be contacted as requested and '*...domestic abuse questions asked*'. This was done at 5.20pm the same day when PC1 contacted Simon and gave him advice.
- 11.3.21 On 25th June, Rosemary contacted Kent Police and spoke to a call handler in the [Force Control Room \(FCR\)](#). She reported that Simon had been putting more posts on his social media applications, some of which she found offensive. She and Simon had blocked each other on social media platforms, so she had found out about these posts from friends. The posts did not contain threats; they were like those she had previously reported.
- 11.3.22 The call handler made the decision to send an email to PC1, who was off duty for a couple of days, asking him to deal with the report on his return. This was the area of concern that Rosemary and her parents had about the way in which Kent Police managed the reports about Simon. They felt the approach taken delayed action. This was a valid concern and there is always a balance between assigning the report to an on-duty officer who can deal with it more quickly or deferring it to the officer who knows the background.
- 11.3.23 Previous DHRs have expressed concern about domestic abuse related incidents being dealt with by the police as individual occurrences rather than a pattern of behaviour. This can lead to the victim having to explain the history of abuse repeatedly to officers who have no knowledge of it. Where incidents require immediate response due to the imminent risk of harm, the involvement of officers without that knowledge is correct, but where a less urgent response is suitable, it may be better to maintain consistency. What is important is that an explanation is given to the victim about the course of action being taken.

- 11.3.24 About 9.45pm on 27th June, PC1 returned to work. Having been sent an email about Rosemary's call two days earlier, he called her within ten minutes of his return. She told him that a mutual friend had made her aware of a Facebook posting by Simon on 23th June, in which he had stated he had been cleared by police and nothing further was going to happen.
- 11.3.25 PC1 then spoke to Simon, who said he created the post on Facebook because he did not want his employer to think he was in trouble. PC1 asked him to remove the post, which he did. PC1 then called Rosemary again to let her know the result of his call to Simon. PC1 contacted Rosemary and then Simon within 20 minutes of his return to work and resolved the issue Rosemary had raised. This was last contact between Kent Police and either Rosemary or Simon until her death on 29th June.
- 11.3.26 Kent Police staff were involved with Rosemary and Simon during a six-day period between the end of their relationship and Rosemary's death. That involvement began when Rosemary, supported by her mother, did the right thing in reporting her concerns about social media posts made by Simon following the end of the relationship.
- 11.3.27 PSE1 accurately summarised Rosemary's initial report on Storm, providing a history for anyone dealing subsequently with the case. Rather than taking initial details and sending Rosemary and her mother away to await further police contact, PSE1 ensured they were seen straightaway by a police officer (PC1). This meant Rosemary benefited from the investigative skills and additional training that police officers receive to deal with stalking and harassment. This was good practice.
- 11.3.28 PC1 carried out a DASH Risk Assessment and researched whether there was recorded history of incidents involving them during their relationship. He then spoke to Simon in the hearing of Rosemary and her mother. Contacting an alleged perpetrator in the hearing of the victim may not be common practice, but in this case it was appropriate. Although Simon said he did not believe he had done wrong, PC1 explained Rosemary's concerns and Simon removed the social media posts.
- 11.3.29 PC1 sought advice from his supervisor to ensure he had taken the right decisions. He did not record the case as a crime, but the Vulnerability Hub did when the case was reviewed there the following day. Two reviews were carried out that day, on the second occasion an action was allocated to PC1 to contact Simon. These reviews are examples of a robust procedure for managing harassment cases. In this case, there is

evidence that Kent Police have good policy and procedures in place, and that staff understand them.

- 11.3.30 There is no record that Rosemary was given contact details of a domestic abuse or specialist stalking support organisation, although she had been asked about a referral to Victim Support, which she declined. Giving contact details would have enabled her, had she so wished, to talk to someone who understood the effects of stalking from a victim's perspective and who may have been able to give her additional advice and support. Staffordshire Police also omitted to do this, and the recommendation is relevant to both forces.
- 11.3.31 Kent Police and Staffordshire Police should give victims of stalking and harassment details of a domestic abuse or specialist stalking support organisation local to the victim. **(Recommendation 2)**
- 11.3.32 Nothing about the involvement that Kent Police had with Rosemary indicated that the situation would escalate so quickly. Based on the facts that were disclosed to him and the conversations he had with Rosemary and Simon, PC1's actions were indicative of someone who understood the nature of social media stalking and harassment. It also suggests that the training Kent Police had given him to deal with such incidents, based on their policies, was robust.
- 11.3.33 The response by Kent Police to Rosemary's initial report, and her subsequent call, was appropriate and proportionate, notwithstanding the tragic outcome so soon after it.
- 11.4 GP Practice 1 (GPP1)
- 11.4.1 Rosemary was registered with GPP1 in Town F throughout the review period. It is a four-partner, single-site training practice. At the time of the review, all partners had received up to date safeguarding training. Following the last Care Quality Commission (CQC) inspection of the practice, it was graded as Outstanding in one of the assessed categories and Good in all others.
- 11.4.2 Except for the last occasion when Rosemary went to her GP, the symptoms she presented with during the review period pre-dated her relationship with Simon. She did not attend more frequently during it, and her attendances were not connected to it. The treatment Rosemary received at GPP1 was appropriate to the conditions she reported.

- 11.4.3 The last time she went to her GP was on 16th June 2017 when her mother was present during the consultation. The record made by the GP of the consultation was *'Vomited on holiday, needed an injection. Thought to be possibly anxiety related.'* Rosemary's mother clearly remembers that Rosemary said to the GP that she was suffering from anxiety due to a relationship she was in coming to an end. She also recalls that the GP prescribed Rosemary medication to treat anxiety.
- 11.4.4 There is no record in Rosemary's GP notes of the discussion about the cause of her anxiety, nor of the prescription. This visit to her GP was the day before Rosemary ended her relationship with Simon and there was no concern about his behaviour then. Rosemary's mother was clear that no concern was expressed to the GP about the relationship, beyond the fact that it was ending.
- 11.4.5 Rosemary's medical records suggest she was comfortable speaking to GPs who gave her the opportunity to discuss more than her physical health. She did not exhibit or disclose anything to her GP that would have given rise to concerns about domestic abuse, stalking or harassment during her relationship with Simon, or at any other time.
- 11.5 GP Practice 2 (GPP2)
- 11.5.1 Simon was registered with GPP2 in Town G throughout the review period. It is a four-partner, single-site training practice. At the time this review was conducted, the last Care Quality Commission (CQC) inspection of the practice was in 2017, when it was graded Good in all assessed categories.
- 11.5.2 During the review period, Simon presented at the practice reporting physical and mental health conditions. The records of the visits about his physical health disclose nothing relevant to the review and are not considered further.
- 11.5.3 On 23rd April 2013, Simon visited a GP (GP1) and reported suffering from depression and suicidal ideation. This was the first time he had presented with mental health problems at the practice. He said he had felt withdrawn for the previous five years, having no friends and being self-confined to his bedroom. He discussed historical mental health issues within his family.
- 11.5.4 GP1 faxed a written referral to the local Community Mental Health Team (CMHT) that day and saw Simon again two days later to review his mental state. Simon said he was feeling more positive and his suicidal ideation

had reduced during the previous two days. He added he was not keen on counselling; he requested medication, which he was prescribed. He also undertook tests used to assess a patient's levels of depression and anxiety.

- 11.5.5 During April and May 2013, Simon was seen at the practice on a regular basis to review his mental health, on all but one occasion by GP1. These appointments were scheduled, which was good practice.
- 11.5.6 On 10th June 2013, GPP2 received a letter from the CMHT explaining that Simon had missed two appointments and not responded to telephone calls. When seen by GP1 the following day, he said he had missed the CMHT appointments and repeated that he was not keen on counselling. He reported that his medication was not working, and he was prescribed an alternative drug.
- 11.5.7 On 4th July 2013, GP1 spoke by telephone to the Community Psychiatric Nurse (CPN1) at the CMHT, who had previously written to the practice. CPN1 said that Simon was being discharged by the CMHT because he had missed appointments and had failed to respond to telephone calls and a letter. GP1 agreed to try to contact Simon.
- 11.5.8 On 15th July 2013, GP1 had a telephone conversation with Simon to discuss his lack of engagement with the CMHT. Simon said he assumed the appointments were for counselling. He again said that he wanted to be treated with medication. He added that he was depressed and thought he might have bipolar disorder. He said his mood fluctuated, and on '*bad days*' he had suicidal ideation. He agreed to a re-referral to the CMHT; GP1 sent a referral letter that day, which was received by the CMHT on 19th July.
- 11.5.9 On 11th September 2013, GPP2 received a letter from CMHT CPN2. Simon had missed an appointment and had not responded to attempts to communicate with him. The CMHT had discharged him and recommended talking therapies as a treatment that might alleviate his suicidal ideation.
- 11.5.10 On 29th October 2013, GP1 had a telephone discussion with Simon and, with his consent, his father. Simon said he missed the CMHT appointment because he was on holiday. He had tried to reschedule it without success. He again mentioned bipolar disorder, referring to a relative who suffered from it, and his reluctance to have counselling. It was agreed that he and his father would discuss alternative treatments and advise the practice of the preferred option.

- 11.5.11 GP1 managed Simon's mental health condition appropriately during this period in 2013. He was seen regularly during the early weeks after he reported suicidal ideation. GP1 did not simply refer Simon to the CMHT and await the response, he arranged review appointments. When Simon was discharged by the CMHT, GP1 contacted him and persuaded him that a re-referral was appropriate. As with the first referral, it was made promptly on the same day Simon saw GP1.
- 11.5.12 There was a slight delay in contacting Simon after the second discharge from the CMHT but when it was made, it included his father, with Simon's consent. This was good practice, the hope being that his father might influence him to accept treatment. Despite GP1's efforts, this did not happen; nothing more was heard from Simon following the call.
- 11.5.13 Simon next reported mental health issues in September 2015, almost two years later. He had seen GPs at GPP2 several times during the intervening period for physical conditions but had not raised his mental health issues.
- 11.5.14 On 10th September 2015, Simon presented to a GP (GP2) reporting suicidal ideation. He said that he had been researching bipolar disorder and felt he had been suffering from this for some time. He had kept a record of his thoughts and actions, and he described behaviour that had put himself in danger. GP2 recorded that Simon did not have '*...any anger towards anyone, with no illusions, delusions, thought control, withdrawal or broadcast.*' A referral, referencing but not diagnosing bipolar disorder, was made to the CMHT that day.
- 11.5.15 On 25th November 2015, GPP2 received a letter from the CMHT recommending a change of medication. This was actioned the following day.
- 11.5.16 On 13th January 2016, Simon was seen by a GP (GP3) and a fitness to work certificate was completed for bipolar disorder, a condition he had not been diagnosed as suffering from. GP3 recorded that Simon told him he was currently under the treatment of the CMHT.
- 11.5.17 On 7th July 2016, Simon saw GP3 to request a further fitness to work certificate. He said he had last been seen by the CMHT five months previously and was currently '*...going through a bad spell*'. GP3 offered to write to the CMHT and did so that day, requesting an urgent follow-up.
- 11.5.18 Simon was seen three times at GPP2 between July 2016 and June 2017, on each occasion for minor physical conditions. He was seen by two GPs

(GP4 and GP5) during this period and his mental state was not mentioned.

- 11.5.19 From September 2015 to the end of the review period, Simon was referred to the CMHT on two occasions when he presented with concerns about his mental health. In contrast with 2013, GPP2 did not hear from the CMHT that Simon was not engaging, so it would have been reasonable for the referring GPs to assume he was.
- 11.5.20 The records made by GPs dealing with Simon were comprehensive and there is nothing that indicates his likelihood of harming anyone other than himself. During the period that he was in a relationship with Rosemary, Simon was seen by GPs for minor physical conditions. There was nothing recorded that would have given them cause to ask about personal relationships.

11.6 Kent & Medway NHS and Social Care Partnership Trust (KMPT)

- 11.6.1 KMPT provides secondary mental health services throughout Kent and Medway. It is delivered in the community by [Community Mental Health Teams \(CMHT\)](#) and [Crisis Resolution Home Treatment Teams \(CRHTT\)](#). KMPT also provides outpatient and inpatient services in its own hospitals, and it deploys liaison psychiatry clinicians in acute hospitals.
- 11.6.2 KMPT also provides a Primary Care Mental Health Service (PCMHS), which is relevant in this case. The PCMHS follows the Government strategy '[No Health without Mental Health](#)', which was published in 2011. It focuses on prevention, promotion and early intervention in mental health, supporting the need for secondary mental health services and primary care services to work collaboratively. Simon was under the PCMHS for part of the review period.
- 11.6.3 In Kent and Medway, the aim of the PCMHS is to enable patients with stable, long-term mental health conditions to be stepped down from secondary care management and effectively managed in primary care.
- 11.6.4 Provision of the PCMHS across Kent and Medway differs according to geographical area, being hosted by KMPT and other providers. The decision as to which agency provides the PCMHS is made by the relevant Clinical Commissioning Group (CCG). For the CCG area in which Simon lived, it was provided by KMPT from 1st March 2016, when there was PCMHS involvement in his case.

- 11.6.5 Rosemary was referred to KMPT twice, in each case by a GP at GPP1. The first occasion was in March 2016, the second in October that year. Neither referral is relevant to the review because the conditions for which she was referred pre-date her relationship with Simon and were unconnected to it.
- 11.6.6 KMPT's first involvement with Simon began on 23rd April 2013, when he was referred by his GP suffering from recent suicidal ideation and long-term depression. The referral was triaged, and Simon was allocated for initial assessment.
- 11.6.7 His first scheduled appointment, on 17th May, was postponed by KMPT but he spoke by telephone to a Community Psychiatric Nurse (CPN1) from the local [Community Mental Health Team \(CMHT\)](#). Following a detailed conversation about his feelings, he was offered an appointment on 30th May. He failed to attend this and after an unsuccessful attempt to contact him by telephone, he was sent a letter offering him an appointment on 10th June.
- 11.6.8 When he did not attend the rearranged appointment, a further unsuccessful attempt was made to contact him by telephone. A letter was then sent to him offering the opportunity to opt-in by contacting the CMHT. A letter was also sent to GPP2, informing the practice of Simon's non-attendance.
- 11.6.9 On 4th July, CPN1 spoke to the referring GP, who confirmed that he had seen Simon twice since he missed the last CMHT appointment. On each occasion Simon had visited to ask for fitness to work certificates. He had not presented with increased mental health symptoms or worsening suicidal ideation. In the light of this, the GP and CPN1 agreed that he should be discharged from the CMHT. CPN1 confirmed this in a meeting with her Team Leader and then sent a letter to the GP confirming the discharge decision.
- 11.6.10 This period between referral and discharge was correctly managed by the CMHT in accordance with the KMPT Did Not Attend (DNA) policy. Alternative methods of communication were tried, Simon's GP was consulted and there was supervisory input in the decision to discharge him from the CMHT.
- 11.6.11 On 19th July 2013, CPN1 received a telephone call from Simon's step-mother asking if he had an appointment arranged with the CMHT. She was told that Simon had been discharged because of his non-

engagement and that his GP was aware of this. His step-mother said he had visited his GP and requested a re-referral to the CMHT.

- 11.6.12 The same day, the CMHT received a faxed re-referral from Simon's GP. It noted that Simon had no worsening symptoms but continued to have suicidal thoughts and did not appear to be responding to treatment (prescribed medication). This referral was triaged, and an unsuccessful attempt was made to contact Simon by telephone. CPN2 sent him a letter offering him an appointment on 14th August.
- 11.6.13 On 11th September 2013, CPN2 sent a letter to Simon's GP stating that he had failed to attend his appointment on 14th August. CPN2 said she had tried to contact Simon without success, although there is no record of these attempts being made. Acknowledging his reluctance to have counselling, CPN2 suggested that talking therapy might help to alleviate his suicidal feelings.
- 11.6.14 During the period between the second referral and discharge, any attempts made to communicate with Simon following his missed appointment were not recorded. There is no record of a supervisory input into the decision to discharge him, nor that he was sent a letter advising him of this action.
- 11.6.15 Following the first referral, Simon did not attend appointments, nor did he respond to subsequent communications. It may have been felt that the second referral was so soon after this, that full compliance with the DNA policy was not required. If that was the rationale, it was not recorded. KMPT's DNA policy was not being consistently implemented during 2013 within this CMHT.
- 11.6.16 It was more than two years later, on 1st October 2015, when the CMHT received the next referral relating to Simon. In part, it was consistent with those in 2013: he was experiencing suicidal ideation and had become socially withdrawn. In addition, the referral from his GP set out feelings that Simon had recorded, such as feeling super human, invincible and taking new activities to extreme levels. It also noted that while on holiday in Australia, he had done things that presented a danger to himself, but not to others. These manic thoughts and actions were potential symptoms of bipolar disorder. The referral went on to mention that Simon stated there was a history of this condition in his family.
- 11.6.17 The following day, 2nd October, a telephone call was made to Simon by CPN2. It was answered by his step-mother, but he then spoke to CPN2. He described his feelings in detail and said that he could share his

suicidal thoughts with his father and step-mother, who he lived with. He was given a contact number for the [CHRTT](#). There is no record that he used this.

- 11.6.18 On 2nd November 2015, Simon was seen at the CMHT by a psychiatrist and CPN2. He was told his symptoms were suggestive of bipolar disorder, but he was not formally diagnosed with this condition. Potential medication options were discussed, and he was given information leaflets, so that he could consider treatment options. It was agreed that he would contact the CMHT when he had decided which option he felt would be best for him.
- 11.6.19 On 9th November 2015, CPN2 spoke to Simon by telephone as he had not made contact about his preferred choice of medication. He said he had been unable to decide and needed further help to make that decision. An appointment was made for him to meet professionals on 20th November. Following this, on 25th November, a medication plan was set by a psychiatrist and this was faxed to Simon's GP.
- 11.6.20 On 4th December 2015, it was recorded that Simon had been seen by CPN2 to discuss his medication plan. He reported no side effects and was happy to continue with it. He said he was not having extreme moods, nor was he having self-harm or suicidal ideation. CPN2 revisited Simon's crisis plan with him as she was going on leave. This was good practice.
- 11.6.21 On 13th January 2016, a discussion about Simon took place in a KMPT team meeting involving CPN2. It was agreed that the option of transferring Simon's case to the PCMHS would be explored.
- 11.6.22 From 1st October 2015, when his GP referral was received, the CMHT had success in engaging with Simon and there is no record that he missed appointments. A comprehensive record was made of the decisions and action taken. As in 2013, there is no record that Simon expressed any thoughts or intentions of harming anyone else.
- 11.6.23 On 14th January 2016, CPN2 telephoned Simon to discuss his medication. He said that he had visited his GP the previous day, who was unaware that he was under the care of the CMHT.
- 11.6.24. On 26th February 2016, Simon had a meeting with CPN2 and a PCMHS nurse (PCN1). He said that his overall mental state had improved, although he still had bad days. PCN1 explained her role to him, stating that she would contact him about ongoing monitoring of his mental state.

She also explained how he could contact her. Both PCN1 and Simon agreed with his case transfer to the PCMHS.

- 11.6.25 There is no record that Simon's GP was told about the transfer of his case to the PCMHS. On 8th July 2016, the GP wrote to the KMPT Single Point of Access (SPoA) saying that Simon had visited him and said he had not had contact from PCN1. He was now experiencing low mood and thoughts of self-harm.
- 11.6.26 On 12th July 2016, PCN1 telephoned Simon and offered him an appointment on 21st July. He did not attend and PCN1 then tried unsuccessfully to telephone him. There is no record that a letter was sent to Simon or that his GP was told about his non-attendance.
- 11.6.27 There were no further attempts to contact Simon. On 23rd February 2017, PCN1 recorded that Simon had not made contact since July 2016 and he was discharged back to his GP. There was no record of why the decision was made at that time, whether there was supervisory input to the decision, or whether Simon's GP was told of it.
- 11.6.28 After his case was transferred to the PCMHS at the end of February 2016, he did not have any further contact with KMPT and did not receive any treatment or support from the PCMHS. He had been told by PCN1 that he would be contacted and although he was given contact details for the PCMHS, his comments to his GP in July confirm that he was expecting to be contacted.
- 11.6.29 The PCMHS accepts that contact should have been made with Simon before the prompt from his GP. This was not done because there was significant case load pressure on the service at the time. This meant that not all service users were contacted. The '*model of care*' being followed was '*client led contact*' which meant that patients would call on the service when they needed it. There is no record that this model was applied using any risk assessment. Simon was not told that there would be no contact unless he initiated it, so it was reasonable for him to expect to be contacted. People with mental health conditions may be less able to retain contact details given to them in a meeting, so if they are expecting contact, it should be made, at least to reiterate that future contact will need to be initiated by them.
- 11.6.30 The attempt made to contact Simon after he had missed the appointment on 21st July was perfunctory and there was no attempt to contact him again before closing his case in February 2017. This indicates that either

the PCMHS did not adhere to the KMPT DNA policy or that policy does not apply to it.

11.6.31 KMPT must ensure that their DNA policy applies to, and is implemented by, the PCMHS. **(Recommendation 3)**

11.6.32 Simon's case was transferred to the PCMHS when it had been open to the CMHT for 5 months. The 'service specification' is that such a transfer should only be made when a person's case has been open to the CMHT for more than 12 months. Given the pressures the PCMHS was under at the time, it may have served him better if this had been adhered to.

11.6.33 KMPT must ensure that the handover of a case to the PCMHS is managed in a way that ensures PCMHS is able to deliver the required level of treatment and service following it. **(Recommendation 4)**

12. How Organisations Worked Together

12.1 If organisations involved with domestic abuse victims work well together, the risk of harm is reduced by sharing information and ensuring support is provided by the most appropriate organisation(s). It also makes the best use of limited resources. The success of inter-agency working relies on effective communication to ensure that each organisation knows when its services are required and has the information on which to base decisions about action it might take.

12.2 The involvement that Rosemary and Sally had with police forces was such that information sharing or inter-agency working would not have been relevant. In each case, the appropriate agency to deal with their concern was the police.

12.3 During her involvement with health agencies, there is no record that Rosemary told professionals anything that would have raised concerns about her being the victim of domestic abuse or other safeguarding issues. In relation to Simon, he revealed nothing to health professionals that suggested he presented a risk to another person. There is no record that either Rosemary or Simon discussed their personal relationships with health professionals. There were no grounds to share information with agencies outside the medical profession.

12.4 The benefit of more effective inter-agency working is a consistent theme from DHRs. However, this does not apply in this review. There was no reason for organisations to share information, because the issues were reported to the appropriate organisations that had the resources and expertise to manage them.

13. Conclusions

- 13.1 None of the organisations subject of this review had evidence or information that Rosemary was a victim of domestic abuse prior to the end of her relationship with Simon. At the time, her parents did not have concerns about the relationship, beyond some apprehension about her entering a relationship with someone who said he was suffering from bipolar disorder when she had struggled for some years with bulimia.
- 13.2 With hindsight, Rosemary's parents can identify potentially controlling and coercive behaviour by Simon. Rosemary was studying at home during evenings for her final year exams and she refused Simon's requests to see him. He would then come to the house unannounced. Rosemary let him in, and he would sit on her bed watching her study. He knew that after her exams she was intending to take the summer off, so he gave up his job to be with her all the time. Rosemary was angered by this and told him they would not spend all their time together and he should get another job, which he did. Controlling and coercive behaviour is a key element in many cases of domestic abuse. This is something that people, including those who are close to victims, may not identify at the time.
- 13.3 The Home Office should lead a campaign to educate the public about coercive and controlling behaviour and the role it plays in domestic abuse. **(Recommendation 5)**
- 13.4 These indications of potentially obsessive behaviour did not cause undue concern at the time and were not the cause of Rosemary ending the relationship, which she felt had run its course.
- 13.5 When their relationship ended, Simon attempted to use coercion to persuade Rosemary to resume it. She and her mother did the right thing in reporting this to Kent Police at an early stage. This did not prevent her death, but it must not deter other victims from reporting behaviour they are being subjected to as soon as it causes them concern.
- 13.6 When Rosemary was asked by the police officer dealing with her report if Simon has been violent towards her during their relationship, she said he had not. He stalked and harassed her using text messaging and social media after their relationship ended. His social media posts were an attempt to coerce her into resuming their relationship and although he did not threaten violence, she was frightened by them. An indication of this is that when her parents were intending to go on holiday, they gave neighbours copies of a photograph of Simon, so they might recognise him if

he turned up at Rosemary's home. This reaffirms how frightening stalking and harassment can be, even without any threat of violence.

- 13.7 Simon cooperated with Kent Police on both occasions when they spoke to him, although it is now known that he had bought the knife used to kill Rosemary before she first reported him. Her tragic death shows how the end of a relationship can trigger obsessive behaviour, with a rapid escalation to stalking, harassment and violence.
- 13.8 The stalking and harassment that Simon subjected Sally to in 2013 became explicitly threatening and sinister, but it did not escalate to physical violence against her.
- 13.9 The use of social media whether by 'private' messaging apps or public posting on sites such as Facebook and Instagram, is the main means by which many people communicate with their family and friends. Social media has become an integral part of many people's lives; they use it to share their activity and events in their life. This is particularly so for those who have grown up since the inception of mobile devices, which are used for most messaging and social media posts. For the majority, this brings social benefits, but as Rosemary's case shows, it can be a vehicle for more sinister activities, including stalking and harassment.
- 13.10 Stalking and harassment by a party to a relationship that has ended happened before the advent of messaging and social media. However, these forms of communication allow the perpetrator to maximise the likelihood of immediate engagement. In addition, the stalker has access to their victim without the need to plan or reflect. As well as targeting the victim directly, the perpetrator may be able to communicate easily with their relatives and friends using social media. This can result in the fear of embarrassment or social rejection, which can be distressing and as pernicious than the fear of violence. Cyberstalking has become the widely used term for stalking using social media or other technology.
- 13.11 There is very little empirical research available worldwide about the specific effects of cyberstalking, perhaps because it is a different means to the same end. Research (*conducted by Jane Monckton-Smith, Karolina Szymanska, and Sue Haile for the Suzy Lamplugh Trust*) suggesting that there is a link between stalking and domestic homicide is available [here](#). Cyberstalking is a subset of the wider behaviour, and this case shows the link to domestic homicide.
- 13.12 The website of [Get Safe Online](#) highlights the risks of cyberstalking, how users can protect themselves and contacts for organisations that can

provide advice for those affected by it. Within Kent and Medway, Community Safety Partnerships should ensure that member organisations know where victims of cyberstalking can be signposted.

(Recommendation 6)

- 13.13 It is important that when stalking and harassment by messaging and social media is reported, the professional who deals with it has a clear understanding of how the medium works. This is not achieved from a learned knowledge of the technical aspects of messaging apps and social media platforms; it must be an understanding gained from using them as part of life. The best people to educate those who use social media about its risks and dangers are those who use it themselves as part of their way of life.
- 13.14 There is no record that Rosemary discussed her relationships with her GP, who would have had no reason to have safeguarding concerns about her. Simon did not give health professionals reason to be concerned that he would harm others. There is no record that he discussed his relationships with them.
- 13.15 The end of a relationship, followed by stalking and harassment, has been the precursor to previous domestic homicides. However, such was the speed at which the escalation to extreme violence took place in this case that even with hindsight, the likelihood of such a tragic outcome could not have been identified.

14. Lessons Identified

14.1 The end of a relationship can be an event that results in the start or escalation of domestic abuse, stalking and harassment

- 14.1.1 Separation may not be the 'solution' to domestic abuse; it may increase the risk to the victim.

14.2 Physical violence is not the only precursor to domestic homicide.

- 14.2.1 Rosemary's death confirms that physical violence is only one indicator of the risk of a domestic homicide. After their relationship ended, Simon attempted to coerce and control her using social media. It is therefore important that all indicators of potential serious harm are identified.

14.3 Social media has become a method of stalking and harassment, which can result in coercion and control even if the victim and perpetrator do not meet or speak to each other.

- 14.3.1 Professionals should treat cases of stalking and harassment by social media as seriously as those which involve direct contact between the parties.

15. Recommendations

15.1 The Review Panel makes the following recommendations from this DHR:

	Paragraph	Recommendation	Organisation
1.	11.2.27	Staffordshire Police must submit a report to the Kent and Medway Community Safety Partnership detailing how, if this case was reported today, the degree of victim focus would be greater, based on their revised Stalking and Harassment Policy.	Staffordshire Police
2.	11.3.31	Kent Police and Staffordshire Police should give victims of stalking and harassment details of a domestic abuse or specialist stalking support organisation local to the victim.	Kent Police Staffordshire Police
3.	11.6.31	KMPT must ensure that their DNA Policy applies to, and is implemented by, the PCMHS.	KMPT
4.	11.6.33	KMPT must ensure that the handover of a case to the PCMHS is managed in a way that ensures the PCMHS is able to deliver the required level of treatment and service following it.	KMPT
5.	13.3	The Home Office should lead a campaign to educate the public about coercive and controlling behaviour and the role it plays in domestic abuse.	The Home Office
6.	13.9	Within Kent and Medway, Community Safety Partnerships should ensure that member organisations know where victims of cyberstalking can be signposted.	Kent and Medway Community Safety Partnerships

Kent & Medway Domestic Homicide Review

Victim – Rosemary Taylor

Terms of Reference

These terms of reference were agreed by the DHR Panel following their meeting on 17 August 2017.

Background

On 29th June 2017, Rosemary Taylor, aged 23 years, was attacked by her ex-boyfriend, Simon Vincent, aged 25 years, as she got into her car in the car park of a shopping centre. He stabbed Rosemary numerous times and she died subsequently of her injuries.

Simon remained at the scene and was arrested on suspicion of causing Rosemary's death. He was later charged with her murder and remanded in custody.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 28th July 2017. It agreed that the criteria for a DHR have been met and, the Chair of the Kent and Medway Community Safety Partnership confirmed that a DHR would be conducted.

That agreement has been ratified by the Chair of the Kent & Medway Community Safety Partnership and the Home Office has been informed.

The Purpose of a DHR

The purpose of a DHR is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-

ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

The Focus of the DHR

This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Rosemary Taylor.

If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

The full subjects of this review will be the victim, Rosemary Taylor, and the alleged perpetrator, Simon Vincent.

DHR Methodology

The DHR will be based on information gathered from IMRs, chronologies and reports submitted by, and interviews with, agencies identified as having had contact with Rosemary and/or Simon in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. The DHR Panel will decide the most appropriate method for gathering information from each agency.

Independent Management Reports (IMRs) and chronologies must be submitted using the templates current at the time of completion. Reports will be submitted as free text documents. Interview will be conducted by the Independent Chairman.

IMRs and reports will be prepared by an appropriately skilled person who has not any direct involvement with Rosemary or Simon, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

Each IMR will include a chronology and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

Each agency required to complete an IMR must include all information held about Rosemary or Simon from 1st January 2013 to 29th June 2017. If any information relating to Rosemary being a victim, or Simon being a perpetrator, of domestic abuse before 1st January 2013 comes to light, that should also be included in the IMR.

Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Rosemary and/or Simon. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2014, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, for example disability, sexual orientation, cultural and/or faith should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Independent Chairman. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Medway CSP.

Specific Issues to be Addressed

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

- i. Were practitioners sensitive to the needs of the Rosemary and Simon, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Rosemary and Simon? Did the agency have

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policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forums?

- iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
- iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?
- viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?
- ix. Was this information recorded and shared, where appropriate?
- x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
- xi. Were senior managers or other agencies and professionals involved at the appropriate points?
- xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

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- xiv. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- xv. Did any staff make use of available training?
- xvi. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- xvii. How accessible were the services to the Rosemary and Simon?

GLOSSARY

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation/Acronym	Expansion
CHRTT	Crisis Resolution and Home Treatment Team
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CPN	Community Psychiatric Nurse
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
DNA (Policy)	(KMPT) Did Not Attend
GP	General Practitioner
IMR	Independent Management Report
Storm	(Staffordshire Police) Incident Management System
IMU	(Kent Police) Incident Management Unit
IOPC	Independent Office for Police Conduct
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KMDASG	Kent and Medway Domestic Abuse Steering Group
NHS	National Health Service
PCMHS	Primary Care Mental Health Service
PCN	Primary Care Mental Health Service Nurse
PIN	Police Information Notice
PNC	Police National Computer
PSE	Police Staff Employee
SPoA	(KMPT) Single Point of Access

Police Information Notice (PIN)

To prove offences of harassment under Sections 2 (harassment) and 2A (stalking) of the Protection of Harassment Act 1997, the prosecution must show a 'course of conduct' by the defendant. To assist in providing evidence of this, most police forces in England and Wales introduced Police Information Notices (PIN), which some referred to as Harassment Notices.

A PIN was served on a person when it was believed that an individual act (which did amount to a criminal offence) had been committed by that person, who knew or ought to have known that the act would cause the victim harassment, alarm or distress. If the person came to notice a second or subsequent time, the PIN could be used to show that they had been warned previously and therefore, their repeated action amounted to a 'course of conduct'.

PINs had no statutory basis and their use became controversial. Her Majesty's Inspectorate of Constabulary and Crown Prosecution Inspectorate considered the use of PINs in the joint report [Living In Fear](#), which was published in July 2017. The report recommended that '*Chief Constables should stop the use of Police Information Notices and their equivalents immediately.*'

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model was agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of 29 pre-set questions will be asked of anyone reporting being a victim of domestic abuse, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

- Standard** Current evidence does not indicate the likelihood of causing serious harm.
- Medium** There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.
- High** There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional question, asking the victim if the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them. If the answer to this question is yes, further questions are asked about the nature of this.

A copy of the DASH questionnaire can be viewed [here](#).

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is:

a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Storm

Storm is the proprietary name for the IT system used by Kent Police to manage incidents.

When a telephone call from a member of the public requesting police assistance is received, a Storm incident log will be created by the call handler. That log is used to record all information received and actions taken in response to the call. Storm automatically records the time an entry is made and the identity of the person making it.

Storm is a networked computer system and can be viewed by most Kent Police officers and staff. The ability to make entries on the system is dependent on a person's role within Kent Police.

THRIVE

Kent Police policy states that requests for service will be evaluated and, where relevant, 'graded' in line with guidance provided within the police service ['National Contact Management Principles and Guidance'](#) and force policing priorities. The 'grade' given to a

request for service determines whether a police response is required and if so, the urgency, speed and nature of it.

Over-arching the above, Kent Police assesses all requests for service utilising the 'THRIVE' principles. THRIVE is a mnemonic for Threat, Harm, Risk, Investigation, Vulnerability & Engagement. Where a force policy, internal working practice or national guidance suggest the grading and/or nature of our response, application of the THRIVE principles against the specific circumstances may determine that a different response is more appropriate to the individual, and the investigation.

Police National Computer

The Police National Computer (PNC) contains information about people and vehicles. The information is accessible to police forces and law enforcement agencies.

Detailed guidance about the PNC, published by the Home Office, can be viewed [here](#).

Police National Database

The Police National Database (PND) is a database that contains intelligence gathered by police forces and other criminal justice agencies across the UK. It allows the police service and other those other agencies to share local information and intelligence on a national basis. Before the introduction of the PND, this intelligence had only been stored on the intelligence systems of individual forces.

The PND supports delivery of three strategic benefits which are to safeguard children and vulnerable people, to counter terrorism, and to prevent and disrupt serious and organised crime. previously only been stored on the intelligence systems of individual forces. It was developed following recommendations from the Bichard Inquiry into intelligence issues arising from the Soham case in 2002.

Genesis

This is the proprietary name for the computer system that Kent Police use to create and store crime reports, [secondary incident reports](#) and criminal intelligence. There is a comprehensive search facility on Genesis. For example, entering a person's name will retrieve all the information held about them by Kent Police. In the case of domestic abuse, it will show the whole history of police involvement including attendance, safety plans and arrests. Genesis also has the facility to store documents such as non-molestation and restraining orders, which will also be retrieved when a person's name is entered. Using a name is only one way to search Genesis; many other search parameters can be entered.

Secondary Incident Report

A secondary incident report is completed by a police officer following attendance at a domestic abuse incident in addition to the [DASH risk assessment](#), when there is no evidence that a criminal offence had been committed.

Community Mental Health Team (CMHT)

CMHTs deliver mental health services to people with long term mental in the community health conditions, rather than at inpatient facilities. CMHTs in Kent and Medway cover geographical areas that are usually coterminous with NHS Clinical Commissioning Groups.

More information about CMHTs can be viewed [here](#).

Crisis Resolution and Home Treatment Team (CRHTT)

The CRHTT is a service set up to respond to and support adults who are experiencing a severe mental health problem which could otherwise lead to an inpatient admission to a psychiatric hospital.

As the name implies, the aim of the team is to resolve the immediate crisis and put in place treatment at a person's home. There are several CRHTTs in Kent & Medway, each of which covers a geographical area.

More information about CRHTTs can be found by clicking [here](#) or at:

<http://www.liveitwell.org.uk/support-help/community-mental-health-teams-cmhts/help-in-a-crisis/>